MDR: M4-02-2404-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $281.50 for date of service 07/31/01.

   b. The request was received on 03/04/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. EOB
   d. Medical Records
   e. Example EOBs from other carriers.
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II: No response found in the case file.

3. Based on Commission Rule 133.307 (g) (4), the Division notified the insurance carrier Austin Representative of their copy of the request on 05/16/02. The Respondent did not submit a response to the request. The "No Response Submitted" sheet is reflected in Exhibit II of the Commission's case file.

4. Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 05/09/02

   "The expected outcome [sic] of this issue is that we feel the claims should be paid in full. In accordance with DME Ground Rules Section IX c states invoices should be billed at the provider's usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and carrier or if no pre-negotiated amount, the fair and reasonable rate. We have billed the Carrier our usual and customary rate and have provided the Carrier with examples of audit sheets and/or copies of checks where other carriers in this area have established these fees as a fair and reasonable amounts as the Commission has not established a MAR for these procedures."

2. Respondent: No position statement found in the case file.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 07/31/01.

2. The explanation of denial listed on the EOBs is "O-OUR REIMBURSEMENT IS BASED ON THE SAN ANTONIO AREA FOR THE SAME TYPE OF ITEMS NOT WHAT OUR COMPETITORS ALLOW."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$ (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
07/31/01	E1399 (leg spacer)	$60.00	$45.00	O	DOP	MFG DME; (X)(IV);(IX)(C) TWCC Act & Rules Sec. 413.011 (d)	The provider has included in their dispute packet, documentation (EOBs from other carriers) that provides some evidence of "fair and reasonable" reimbursement per Sec. 413.011(d). The carrier did not respond to the dispute. Therefore, they had no methodology or produced any evidence of a fair and reasonable rate. The provider has submitted some evidence of a fair and reasonable rate. Therefore, reimbursement is recommended in the amount of **$15.00**.

07/31/01	E1399 (ombus forme seat cushion)	$100.00	$75.00	O	DOP	MFG DME; (X)(IV);(IX)(C) TWCC Act & Rules Sec. 413.011 (d)	The provider has included in their dispute packet, documentation (EOBs from other carriers) that provides some evidence of "fair and reasonable" reimbursement per Sec. 413.011(d). The carrier did not respond to the dispute. Therefore, they had no methodology or produced any evidence of a fair and reasonable rate. The provider has submitted some evidence of a fair and reasonable rate. Therefore, reimbursement is recommended in the amount of **$25.00**.
07/31/01	E0199 (egg crate mattress)	$120.00	$19.00	O	DOP	MFG DME; (X)(IV);(IX)(C) TWCC Act & Rules Sec. 413.011 (d)	The provider has included in their dispute packet, documentation (EOBs from other carriers) that provides some evidence of "fair and reasonable" reimbursement per Sec. 413.011(d). The carrier did not respond to the dispute. Therefore, they had no methodology or produced any evidence of a fair and reasonable rate. The provider has submitted some evidence of a fair and reasonable rate. Therefore, reimbursement is recommended in the amount of **$101.00**.
07/31/01	E1399 (ombus forme back cushion)	$190.00	$142.50	O	DOP	MFG DME; (X)(IV);(IX)(C) TWCC Act & Rules Sec. 413.011 (d)	The provider has included in their dispute packet, documentation (EOBs from other carriers) that provides some evidence of "fair and reasonable" reimbursement per Sec. 413.011(d). The carrier did not respond to the dispute. Therefore, they had no methodology or produced any evidence of a fair and reasonable rate. The provider has submitted some evidence of a fair and reasonable rate. Therefore, reimbursement is recommended in the amount of **$47.50**.
Totals		$470.00	$281.50				The Requestor **is** entitled to reimbursement in the amount of **$188.50.**

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $188.50 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 12th day of February 2003.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

MB/mb